

<b>Case Number:</b>	CM14-0145646		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	06/30/2009
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	08/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 56 year old male who sustained an industrial injury on 5/30/2009. She reported she sustained multiple physical injuries due to constant running, playing, moving furniture, lifting and holding children and getting knocked over. She has been treated long term for neck, shoulder, low back and knee complaints. Treatment over the years has included pain management, epidural injections, psychotherapy, biofeedback physical therapy, chiropractic care, acupuncture, and medications. Per the 12/19/2013 AME she was diagnosed with chronic recurrent musculoligamentous injury cervical spine/trapezius muscle, DDD cervical spine, chronic impingement bilateral shoulder (right greater than left), chronic recurrent musculoligamentous injury of the lumbosacral spine with DDD, early medial compartment osteoarthritis bilateral knees. The AME recommended future medical care to include episodic PT or chiropractic 6-8 visits per year with home core strengthening, prescription pain medication, and anti-inflammatories or muscle relaxants, and 10% probability of subacromial decompression of right shoulder. The prior peer review completed on 8/8/2014 (8/12/2014) non-certified the requests for laser treatments 2x4, chiro 2x4, acupuncture 2x4, and massage therapy 2x4. The requests were not supported by the guidelines, and were not medically necessary. The prior peer review completed on 2/6/2014 modified the request for aquatic therapy 3x4 of bilateral shoulders, bilateral knees, bilateral ankles, bilateral hips, lumbar spine, to allow 6 sessions of land-based therapy. The request for acupuncture was approved for trial of 6 sessions. On 7/14/2014, the requests for aquatic therapy 3x4, acupuncture 2x4 and chiro 2x4 was approved by the UR registered nurse. According to the PTP PR-2 dated 2/24/2014, the presents for follow-up for bilateral shoulders and lumbar spine. She feels she is getting worse due to non-treatment for months. She reports waiting for replacement headset for the one she broke. Physical examination reports she has pain complaints and limited ROM of the shoulder and lumbar spine, positive

impingement and O'Brien's signs. Authorization is requested for aquatic therapy, physical therapy, dermatology specialist, laser specialist, and new headset. She is dispensed oral medications and advised to return in 6 weeks for follow-up. Work status is full duty without restrictions/limitations. According to the PTP PR-2 dated 6/30/2014, the patient is seen for follow-up exam for her lumbar spine, bilateral shoulders, knees, hips, and ankles. She states her right shoulder has been freezing up on her, and her knees have a burning sensation. Physical examination reports limited ROM, stiffness and tenderness to the anterior aspect of the bilateral knees, shoulder, hips and ankles. Aquatic therapy 3x4, chiropractic and acupuncture 2x4, and laser treatments to burst blood vessels on the face, are requested. She is dispensed oral medications and topical compounds, and advised to return in 6 weeks for follow-up. Work status is full duty without restrictions/limitations.

### **IMR ISSUES, DECISIONS AND RATIONALES**

The Final Determination was based on decisions for the disputed items/services set forth below:

**Laser treatments 2x4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Low Level Laser Therapy (LLLT).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Low-Level Laser Therapy (LLLT) Page(s): 57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Low level laser therapy (LLLT)

**Decision rationale:** The ACOEM guidelines state "Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms." According to the CA MTUS and Official Disability Guidelines, cold laser or LLLT, is not recommended. There has been interest in using low-level lasers as a conservative alternative to treat pain. Studies have concluded that there are insufficient data to draw firm conclusions about the effects of LLLT for low-back pain compared to other treatments, different lengths of treatment, different wavelengths and different dosages. This form of treatment is not recommended as efficacy is not established. According to the 6/30/2014 PR-2, laser treatments to treat burst blood vessels on the face is requested. However, the medical records do not provide any documentation of an injury, subjective complaints, and objective findings, as well as how this relates to the patient's 6/2009 industrial injury. The requested treatment appears cosmetic in nature and not clearly medically necessary. In addition, laser treatment is not recommended per the guidelines. The request is not deemed medically necessary, and is not recommended.

**Chiropractic 2x4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

**Decision rationale:** The CA MTUS guidelines recommend Manual therapy & manipulation for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. The patient has undergone extensive treatment over the years, including an unknown number of chiropractic treatments. The medical records do not provide adequate documentation regarding her prior chiropractic care. It is unclear when she last attended chiropractic, the number of sessions completed, and there is lacking documentation to support that she obtained clinically significant functional improvement with prior treatment. There is no mention of utilizing any core strengthening home exercise program. Furthermore, the minimal findings on examination do not establish significant deficits exist as to support consideration for additional active care for this June 2009 industrial injury, more than 5 years past. The medical necessity of the request is not established.

**Acupuncture 2x4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** According to the guidelines, "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery.(1) Time to produce functional improvement: 3 to 6 treatments.(2) Frequency: 1 to 3 times per week.(3) Optimum duration: 1 to 2 months.(d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(ef). Reportedly, the patient has responded well to acupuncture in the past, however, there lacks documentation of benefit in the medical records to corroborate this claim. It is not demonstrated that the patient presents with an exacerbation or flare-up that necessitates further treatment. There is no mention of utilizing any core strengthening home exercise program. The PR-2 dated 6/30/2014 documents the patient has complaints of pain, with tenderness and limited ROM. The report does not document objective examination findings demonstrating significant functional deficits on examination that would potentially benefit with additional acupuncture care. The guidelines state Acupuncture may be extended if functional improvement is documented. However, the medical records do not establish clinically significant improvement in objective findings, and/or reduction in pain and medication use. The medical necessity is not established.

**Massage Therapy 2x4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

**Decision rationale:** According to CA MTUS guidelines, massage treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. Scientific studies show contradictory results. Furthermore, many studies lack long-term followup. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. The medical records document the patient has received physiotherapy treatments and modalities which would have included massage. The medical records do not establish clinically significant objective functional improvement with the rendered passive therapy. Massage is a passive intervention and treatment dependence should be avoided. The request is not medically necessary.